



Reprinted
January 29, 2008

SENATE BILL No. 331

DIGEST OF SB 331 (Updated January 28, 2008 8:12 pm - DI 110)

Citations Affected: IC 27-8; IC 27-13; noncode.

Synopsis: Health coverage for dependents. Defines "dependent" for purposes of the laws regulating policies of accident and sickness insurance and health maintenance organization contracts. Amends provisions requiring coverage of certain children to require coverage of dependents under a policy of accident and sickness insurance or a health maintenance organization contract. Removes a provision requiring coverage of any dependent upon request under an individual policy of accident and sickness insurance.

Effective: July 1, 2008.

Mishler, Smith S

January 10, 2008, read first time and referred to Committee on Insurance and Financial Institutions.

January 24, 2008, reported favorably — Do Pass.

January 28, 2008, read second time, amended, ordered engrossed.

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SB 331—LS 6827/DI 97+



Second Regular Session 115th General Assembly (2008)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2007 Regular Session of the General Assembly.

SENATE BILL No. 331

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 27-8-5-1, AS AMENDED BY P.L.173-2007,
2 SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2008]: Sec. 1. (a) The term "policy of accident and sickness
4 insurance", as used in this chapter, includes any policy or contract
5 covering one (1) or more of the kinds of insurance described in Class
6 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual
7 basis under this section and sections 2 through 9 of this chapter, on the
8 group basis under this section and sections 16 through 19 of this
9 chapter, on the franchise basis under this section and section 11 of this
10 chapter, or on a blanket basis under section 15 of this chapter and
11 (except as otherwise expressly provided in this chapter) shall be
12 exclusively governed by this chapter.

13 **(b) As used in this chapter, "dependent" means, with respect to**
14 **a policyholder or certificate holder, an individual who:**

15 **(1) is a:**

16 **(A) biological or legally adopted child who receives any**
17 **support from the policyholder or certificate holder; or**

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(B) child for whom the policyholder or certificate holder has a legal guardianship or who is a stepchild, grandchild, or other blood relative of the policyholder or certificate holder and who receives more than fifty percent (50%) of the dependent's total support from the policyholder or certificate holder;

(2) resides with the policyholder or certificate holder at least six (6) months of the year, with exceptions for divorce, separation, or temporary absences, including absences for illness, education, business, vacation, or military service;

(3) is unmarried;

(4) is not eligible for group coverage for health care services through the individual's employer; and

(5) does not have coverage for health care services.

(c) An insurer may annually require proof of financial dependency of an individual described in subsection (b)(1)(B).

~~(b)~~ (d) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy, until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with and reviewed by the commissioner under section 1.5 of this chapter. This section is applicable also to assessment companies and fraternal benefit associations or societies.

SECTION 2. IC 27-8-5-2, AS AMENDED BY P.L.218-2007, SECTION 45, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy must insure **at the request of the policy holder**, originally or by subsequent amendment, ~~upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age~~, any two (2) or more eligible members of that family, including: ~~husband; wife; dependent children; or any children who are less than~~

(A) a spouse; and

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(B) a dependent of the policyholder or spouse until the date the dependent becomes twenty-four (24) years of age. and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) **Notwithstanding subdivision (3)**, if an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent ~~child~~ terminates upon attainment of the limiting age for ~~dependent children~~ **dependents** specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of ~~such child the dependent~~ while the ~~child dependent~~ is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

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(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the ~~child's~~ **dependent's** attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the ~~child's~~ **dependent's** attainment of the limiting age subsequent proof of the ~~child's~~ **dependent's** disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who ~~is a child who~~ has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

SECTION 3. IC 27-8-5-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 18. (a) Except for a policy that conforms to the description in section 16(2) of this chapter, a group accident and sickness insurance policy may be extended to insure the employees or members, or any class or classes of employees or members, with respect to their family members or dependents, subject to subsections (b) and (c).

(b) The premium for the insurance must be paid from funds contributed by the employer, union, association, or other person to whom the policy has been issued or from funds contributed by the

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covered persons, or from both sources of funds. Except as provided in subsection (c), a policy on which no part of the premium for the coverage of family members or dependents is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and ~~dependent children~~ **dependents**.

(c) Except as provided in section 24 of this chapter, an insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

SECTION 4. IC 27-8-5-19, AS AMENDED BY P.L.173-2007, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

- (1) the provisions described in subsection (c); or
- (2) provisions that, in the opinion of the commissioner, are:
 - (A) more favorable to the persons insured; or
 - (B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made,

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unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months

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beginning on the effective date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

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The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:

(i) not more than forty-five (45) days after the insurer's (as

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defined in IC 27-8-5.7-3) receipt of written proof of loss if the claim is filed by the policyholder; or

(ii) in accordance with IC 27-8-5.7 if the claim is filed by the provider (as defined in IC 27-8-5.7-4); and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars (\$5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer, at the insurer's expense, has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

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(17) **Notwithstanding section 28 of this chapter**, if the policy provides that hospital or medical expense coverage of a dependent ~~child~~ of a group member terminates upon the ~~child's~~ **dependent's** attainment of the limiting age for ~~dependent children~~ **dependents** set forth in the policy, a provision that the ~~child's~~ **dependent's** attainment of the limiting age does not terminate the hospital and medical coverage of the ~~child~~ **dependent** while the ~~child~~ **dependent** is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the ~~child's~~ **dependent's** incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the ~~child's~~ **dependent's** attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the ~~child's~~ **dependent's** attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the ~~child's~~ **dependent's** attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a ~~child~~ **dependent** who has mental retardation or a mental or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the ~~child~~ **dependent**.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it

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consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

- (1) obtain a certificate described in subsection (c)(8); and
- (2) request the certificate in paper form.

SECTION 5. IC 27-8-5-28, AS ADDED BY P.L.218-2007, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a **child dependent** of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the **child dependent** becomes twenty-four (24) years of age.

SECTION 6. IC 27-13-1-11.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 11.5. (a) "**Dependent**" means, with respect to a subscriber, an individual who:

(1) is a:

- (A) biological or legally adopted child who receives any support from the subscriber; or
- (B) child for whom the subscriber is a legal guardian, stepchild, grandchild, or other blood relative who receives more than fifty percent (50%) of the individual's total support from the subscriber;

(2) is an Indiana resident;

(3) is unmarried;

(4) is not eligible for group coverage for health care services through the individual's employer; and

(5) does not have coverage for health care services.

(b) A health maintenance organization may annually require proof of financial dependency of an individual described in subsection (a)(1)(B).

SECTION 7. IC 27-13-7-3, AS AMENDED BY P.L.218-2007, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

- (1) The name and address of the health maintenance organization.
- (2) Eligibility requirements.
- (3) Benefits and services within the service area.
- (4) Emergency care benefits and services.
- (5) Any out-of-area benefits and services.

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- 1 (6) Copayments, deductibles, and other out-of-pocket costs.
- 2 (7) Limitations and exclusions.
- 3 (8) Enrollee termination provisions.
- 4 (9) Any enrollee reinstatement provisions.
- 5 (10) Claims procedures.
- 6 (11) Enrollee grievance procedures.
- 7 (12) Continuation of coverage provisions.
- 8 (13) Conversion provisions.
- 9 (14) Extension of benefit provisions.
- 10 (15) Coordination of benefit provisions.
- 11 (16) Any subrogation provisions.
- 12 (17) A description of the service area.
- 13 (18) The entire contract provisions.
- 14 (19) The term of the coverage provided by the contract.
- 15 (20) Any right of cancellation of the group or individual contract
- 16 holder.
- 17 (21) Right of renewal provisions.
- 18 (22) Provisions regarding reinstatement of a group or an
- 19 individual contract holder.
- 20 (23) Grace period provisions.
- 21 (24) A provision on conformity with state law.
- 22 (25) A provision or provisions that comply with the:
- 23 (A) guaranteed renewability; and
- 24 (B) group portability;
- 25 requirements of the federal Health Insurance Portability and
- 26 Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).
- 27 (26) That the contract provides, upon request of the subscriber,
- 28 coverage for a ~~child~~ **dependent** of the subscriber until the date the
- 29 ~~child~~ **dependent** becomes twenty-four (24) years of age.
- 30 (b) For purposes of subsection (a), an evidence of coverage which
- 31 is filed with a contract may be considered part of the contract.
- 32 SECTION 8. [EFFECTIVE JULY 1, 2008] (a) **IC 27-8-5-1,**
- 33 **IC 27-8-5-2, IC 27-8-5-18, IC 27-8-5-19, and IC 27-8-5-28, all as**
- 34 **amended by this act, apply to a policy of accident and sickness**
- 35 **insurance that is issued, delivered, amended, or renewed after June**
- 36 **30, 2008.**
- 37 (b) **IC 27-13-1-11.5, as added by this act, and IC 27-13-7-3, as**
- 38 **amended by this act, apply to an individual contract or a group**
- 39 **contract that is entered into, delivered, amended, or renewed after**
- 40 **June 30, 2008.**

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SENATE MOTION

Madam President: I move that Senator Smith S be added as coauthor of Senate Bill 331.

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COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 331, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 331 as introduced.)

PAUL, Chairperson

Committee Vote: Yeas 10, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 331 be amended to read as follows:

Page 2, line 1, after "certificate holder" insert "**has a legal guardianship or who**".

Page 2, line 2, delete "legal guardian,".

Page 2, line 3, after "relative" insert "**of the policyholder or certificate holder and**".

Page 2, line 4, delete "individual's" and insert "**dependent's**".

Page 2, line 6, delete "is an Indiana resident;" and insert "**resides with the policyholder or certificate holder at least six (6) months of the year, with exceptions for divorce, separation, or temporary absences, including absences for illness, education, business, vacation, or military service;**".

Page 2, line 32, delete "insure," and insert "**insure at the request of the policy holder,**".

Page 2, line 36, delete "including," and insert "including:".

Page 2, line 37, delete "at the request of the policyholder:".

(Reference is to SB 331 as printed January 25, 2008.)

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